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**Statement
of the
American Hospital Association
before the
Health Subcommittee
of the
Committee on Energy and Commerce
of the
U.S. House of Representatives**

**“Hearing to Review Bipartisan Legislation to
Strengthen Post-Acute Care for Medicare Patients”**

April 16, 2015

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to provide input on the Bundling and Coordination Post-Acute Care (BACPAC) Act of 2015. BACPAC would bundle payments for post-acute care services provided during the 90 days following a hospital discharge. The payment amount would be determined based on a new system that would calculate an amount based on the patient’s age, overall health and the condition being treated. Under the bill, a variety of entities could serve as a bundled payment convener, including hospitals, post-acute care providers and insurers. For eight years, beginning in fiscal year (FY) 2020, bundled payments for these services would be set at 96 percent of what would have otherwise been paid under Medicare fee-for-service.

There is widespread agreement that new payment and delivery models are needed to improve our health care system to achieve a better patient experience, better population health and lower per-capita costs. Our members are testing many new payment models in both the public and private sectors – there is still much work to be done, with many potential paths and policies available.

As this work is ongoing, the AHA believes now is the time to dedicate resources toward building the knowledge base needed to improve our health care delivery system by testing new models on a small scale and using the lessons learned to develop proposals before considering widespread adoption and implementation.



Bundling payments is a complex undertaking in which post-acute care plays a critical role. Our members strive to provide the right care in the right setting, but a lack of care coordination in the fee-for-service system produces significant variation in how patients receive post-acute care. Clinically similar patients experience a wide array of post-acute care clinical “pathways.” In fact, the AHA has conducted an extensive [analysis](#) that shows there are more than 8,800 different patient pathways, with significant variation in the type and total count of unique post-acute visits, in the 60 days following hospital discharge. Even when looking at selected high-frequency conditions, there are still more than 1,000 unique clinical pathways following discharge.

Our analysis and other research also show that the first care setting after discharge from a general acute-care hospital is a major driver of both the clinical pathway the patient will follow and the overall Medicare payment for that episode of care. Thus, bundled payment arrangements present many opportunities to re-tool the types and mix of post-acute care, and materially improve patient care and lower costs. Such efforts may include more standardized hospital discharge practices and post-hospitalization protocols for medical, rehabilitation and other post-acute care services. However, bundled payment arrangements also present many challenges, as providers will face substantial risk if they do not have tools available to understand and select the post-acute and other services that will achieve the best outcome for a given patient.

The AHA agrees that several key elements of BACPAC are a step in the right direction. However, we also have concerns with the bill, which include its potential to preempt valuable work already undertaken in this area; its reliance on the “Continuity Assessment Record and Evaluation (CARE) Tool” as a patient assessment instrument; and its inappropriate adjustment for readmissions. Our detailed comments are outlined below.

BACPAC CONTAINS MANY POSITIVE ELEMENTS

We support several elements of the BACPAC bill, which would build stakeholder support for the bundled payment model, as well as contribute to successful bundling payment outcomes. For example, we appreciate that this bundling approach would allow post-acute care providers to engage as conveners. Indeed, post-acute care organizations are actively engaged in the Center for Medicare and Medicaid Innovation’s Bundled Payments for Care Improvement (BPCI) initiative. And they are interested in continuing to lead and shape the development of payment and other health care reforms. We also support the bill’s longer episode window of 90 days, which we believe aligns with a post-acute-only model since many patients receive post-acute care for elongated periods, such as home health (HH) patients treated for one or more 60-day episode, and higher-acuity patients in the long-term care hospital (LTCH), inpatient rehabilitation facility (IRF) and skilled-nursing facility (SNF) settings.

In addition, we strongly support the waiver of post-acute care regulations that could otherwise artificially restrict the provision of the most appropriate patient care, including the LTCH “25% Rule,” the IRF “60% Rule,” the SNF three-day stay requirement and the HH face-to-face requirement. Further, we appreciate that BACPAC’s post-acute regulatory waivers are more comprehensive than those offered to participants in the BPCI program. These regulations do not make sense in a bundled payment scenario and waiving them would give valuable flexibility in

designing new approaches to increase quality, reduce unnecessary costs and craft more streamlined clinical pathways that fit each patient's unique medical needs.

BACPAC COULD PREEMPT ONGOING WORK WITH BUNDLED PAYMENT MODELS

Overall, the AHA believes it would be most productive to allow the Centers for Medicare & Medicaid Services (CMS) to focus on completing its work on bundled payment under the BPCI initiative, which is well underway, before committing to a particular bundled payment approach for post-acute care. BACPAC would defer full development of many core bundled payment policies to CMS, including payment rates, a payment process, provider network requirements, a patient assessment process and quality standards. Yet, variations on these policies are being developed and tested in the BPCI initiative at this time. Committing to a specific approach now could preempt BPCI's results and preclude CMS from utilizing the lessons learned to create the best and most effective bundling models possible.

More specifically, the Affordable Care Act (ACA) authorized the testing of multiple innovations such as bundled payment and shared savings approaches – both of which could fundamentally change the role of post-acute care. Under the BPCI initiative, four bundled payment models were rolled out in 2012 and are currently being tested in the marketplace. These demonstrations are intended to inform policymakers about realistic payment, operational and clinical practices on which to base a sound, national bundled payment program. Similar to the BACPAC bill, one of BPCI's models is a post-acute care only approach; 20 groups representing 81 providers are currently actively testing this model.

In addition, the BACPAC bill needs to be examined in the context of and harmonized with current law. Specifically, attempting to layer BACPAC's patient assessment, quality measure and payment requirements on top of those established by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, which is expected to be the subject of rulemaking in the coming weeks, would be duplicative and premature. Through the IMPACT Act, Congress mandated that CMS develop long-desired infrastructure for consistent patient assessment and quality data for all post-acute settings: LTCHs, IRFs, SNFs and HH agencies. The data collected under IMPACT will enable analysis and comparisons of patient acuity, treatments, cost of care, outcomes and more across the four post-acute settings. Such cross-setting analyses will be insightful for policymakers and providers working on current and future improvements to post-acute care. These new insights will help shape the ongoing re-tooling of bundling, shared savings and other innovations that are in the testing stage.

CONCERNS WITH THE USE OF THE CARE TOOL

The AHA finds the bill's potential use of the "CARE Tool" as a patient assessment instrument problematic. While we recognize the value of patient assessment instruments to help ensure clinically appropriate placement into the setting immediately following hospitalization, the CARE Tool has significant weaknesses. First, it is not actually designed to yield a recommendation as to the most clinically appropriate placement post-hospitalization. In addition, it has been widely criticized for its length and for its inability to capture the full spectrum of medical acuity for post-acute care patients – particularly for those with the highest acuity.

CMS itself is aware of the CARE Tool's shortcomings within a bundled payment context – it had been slated for use in the BPCI initiative but was ultimately tabled. At first, providers had requested a shorter, less burdensome version, which resulted in the development of the “B-CARE Tool.” However, even the B-CARE Tool was found to be too time-consuming while, at the same time, not offering any “added advantage” toward improving the care of patients, since most organizations already have procedures in place to gather the relevant data. A further critique is that the tool provides only a single point-in-time assessment and does not provide sufficient evidence of rehabilitative trends or changes in functional status within the episode. Ultimately, the B-CARE Tool, which was withdrawn from use in BPCI, may be more useful for providing case-mix adjustments for Medicare episode payments, and less useful as a patient assessment instrument.

Instead, post-hospital placement should be based on patients' clinical needs, and discharge planning tools should incorporate physician and other clinicians' judgment, be administratively feasible, not add to current reporting burdens and help clinicians optimize health during a hospital stay and facilitate restoration of function. Recognizing this, hospitals and health systems have actively sought innovative ways to help ensure that patients are discharged to the most appropriate care setting, with the ultimate goal of improving the overall quality of care for patients and reducing readmissions. Rather than using the unwieldy CARE Tool, many organizations have developed their own patient discharge tools designed to reduce variation in post-hospital placement and avoidable readmissions. To that end, in January, the AHA issued a [report](#) highlighting the efforts of five organizations working to improve patient care transitions through the development and implementation of hospital discharge planning tools.

CONCERNS WITH THE PROPOSED READMISSION POLICY

Finally, the AHA is concerned that the BACPAC bill's proposed adjustment for readmissions is inappropriate and unnecessary. Specifically, it would reduce the amount of a bundled payment by the aggregate amount paid for any readmissions to acute care hospitals within the 90-day episode covered by the bundle.

We certainly agree that reducing unnecessary readmissions is an important goal. However, the bill fails to recognize that not all readmissions can, or should, be prevented. While some readmissions may be avoided if the patient receives the right care at the right time, others may be unavoidable due to the natural progression of disease, accepted treatment protocol or a patient's preferences. Some readmissions are part of a planned course of treatment. Furthermore, the structure of a bundled payment already creates a strong incentive for providers to reduce readmissions. A basic assumption behind most bundled payment arrangements is that they create a financial incentive to coordinate care across settings, and provide less costly care interventions where appropriate to reduce the need for inpatient hospital services.

In summary, the AHA appreciates the opportunity to share our feedback on the BACPAC bill. Now is the time for testing and learning rather than adoption and implementation. We support the bill's broader objective of improving care and bringing new efficiencies to the

delivery system. We encourage continued discussion and policy work to develop a sound post-acute care only bundle payment model.